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Supreme Court of the United States

October Term, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health, DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF FOR THE SELF-INSURANCE INSTITUTE OF AMERICA, INC., AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICUS SELF-INSURANCE INSTITUTE OF AMERICA

The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of Petitioners and Respondents.[1]

SIIA is a non-profit corporation composed of over 1,200 members dedicated to the advancement and protection of (1) an employer's choice to purchase insurance or to self-fund employee benefit plans, (2) the industry that has developed to facilitate the self-funding alternative and (3) the principles of the Employee Retirement Income Security Act of 1974 ("ERISA"). It was the passage of ERISA in 1974 that freed employers from state laws requiring employers to buy commercial insurance to provide employee benefits.[2]

SIIA's membership includes employer/plan sponsors, service providers to plan sponsors and plans and other entities engaged in the administration of self-funded ERISA plans. Members of SIIA are directly involved in the health care coverage of tens of millions of Americans in every state of the Union. SIIA is the only association in the United States which represents firms, professionals and organizations which participate in a broad spectrum of self-funding for ERISA plans.

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[1] Original consent letters from Petitioners and Respondents have been lodged with the Court.

[2] This was accomplished by Congress' (i) declaring employee benefit plans to be separate legal entities (ERISA §502(d), 29 U.S.C. §1132(d)) and (ii) invalidating state laws that "relate to" these new, separate federal legal entities (ERISA §514(a), 29 U.S.C. §1144(a)).

Through SIIA, its members coordinate their views and provide practical information and recommendations to federal and state governments and the public on how the self-funding employee benefits system functions and the interplay between state and federal law, particularly ERISA and the freedom of choice that ERISA provides employers and the administrators of ERISA plans. This includes rendering assistance to courts in their deliberations on significant ERISA issues of broad concern to SIIA members and the public.[3]

SIIA has a particular interest in the ERISA pre-emption issues presented by the tax imposed by New York's 1990 Health Facility Assessment law[4] ("HFA Tax Law"). If the State of New York's efforts to directly tax ERISA plans are upheld by this Court, then the death knell may well have sounded for the principle that ERISA plans can operate free from state regulations.

Indeed, the State of New York, emboldened by its apparent victory in *New York State Conference and Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company, et al.*,[5] (*"Travelers"*) has already enacted a new

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[3] In addition to filing numerous *amicus* briefs with the United States Supreme Court and many U.S. Courts of Appeals, SIIA has also been the associational plaintiff in a number of ERISA pre-emption cases involving self-funded ERISA plans. These cases include *SIIA v. Gallagher*, 11 EBC (BNA) 2162 (N.D. Fla. 1989), *aff'd without opinion*, 909 F.2d 1491 (11th Cir. 1990) and *SIIA v. Korioth*, 993 F.2d 479 (5th Cir. 1993).

[4] N.Y. Pub. Health Law §§2801(1), 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993).

[5] 514 U.S. ___, 115 S. Ct. 1671 (1995).

taxing measure to be effective January 1, 1997.[6] The 1997 New York Hospital Tax Act is designed to raise as much as $2.6 billion dollars a year, largely from ERISA plans located throughout the United States, to be used (1) to provide health care to indigent New Yorkers, (2) to subsidize medical education in the State of New York and (3) to fund state health care initiatives by the State of New York.[7] This new New York Tax Act assesses a tax of between 8.18% and 57.27% on all ERISA plans that happen to pay a participant or beneficiaries' medical bill to a New York Hospital, even if the employer/plan sponsor and plan participants and beneficiaries all reside and do business outside the State of New York.[8] A plan participant's serious illness while vacationing in New York City can cost an ERISA plan operating in California tens of thousands of dollars in New York taxes that the ERISA plan did not know about, did not plan for, and did not prefund. ERISA pre-emption was enacted by Congress to preclude this very result.

It is vitally important to the future of ERISA plans (and the carrying out of the Congressional intent evidenced by Section 514(a) of ERISA, 29 U.S.C. §1144(a))

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[6] The New York Health Care Reform Act of 1996 (S 7954) (*adding* N.Y. Public Health Law §§2807-j, 2807-s and 2807-t) ("1997 NY Hospital Tax Act"). Exhibit A is an article from the 8/26/96 issue of the *New York Law Journal* that summarizes some of the salient points of this new state tax law.

[7] Exhibit A at page 3.

[8] The variation in the applicable tax rates depends upon whether or not representatives of the affected ERISA plans agree to pay the State of New York directly and consent to the jurisdiction of other New York courts. See Exhibit A.

that the holding in *Travelers* be limited to state laws having "[non]acute, albeit indirect, economic effects"[9] on the benefits and administrative schemes of ERISA plans. If *Travelers* is read to allow the direct taxation of ERISA plans, it will be but a short time before the regulation of ERISA plans will be balkanized into 50 fiefdoms, controlled by the taxing authorities of each of the several States and the "crowning achievement"[10] of ERISA, that 22 years ago gave employers and plan administrators freedom of choice, will be lost.

Unfortunately, *Travelers* has been read by Petitioners, the State of New York, and/or the Solicitor General of the United States (on behalf of the U.S. Department of Labor) as supporting the propositions that Congress did not intend for ERISA to pre-empt either state laws regulating traditional areas of local concern or state laws of general applicability. SIIA believes that neither Congressional intent nor this Court's holding in *Travelers* supports this proposition because it would strike at the heart of the Congressional purpose for ERISA pre-emption:

> "To avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1677.

Accordingly, SIIA submits this *amicus curiae* Brief in support of Respondents.

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[9] *Travelers*, 115 S. Ct. at 1683.

[10] Remarks of Representative Dent, 120 Cong. Rec. 29197 (1974) (*quoted* in *Shaw v. Delta Airlines*, 463 U.S. 85, 99, 103 S. Ct. 2890 (1983)).

SUMMARY OF THE ARGUMENT

The holding of this Court in *Travelers* underscores that there cannot be any simple bright line test for ERISA pre-emption. The scope of pre-emption must be determined by the facts and circumstances of each case, keeping ERISA's objectives in mind, *i.e.*, fostering the provision of pension and welfare benefits by employers and employee organizations through the voluntary creation of employee benefit plans that are subject to a single uniform federal regulatory regime. *Travelers*, 115 S. Ct. at 1677.

Consistent with this objective, ERISA does not require a particular type of administrative scheme for ERISA welfare plans. Benefits may be provided by insurance, self-funding, or the provision of in-kind services, however the employer or the employee organization choose to have them provided. These choices are an essential part of the design and administrative scheme of each ERISA plan. The choice of how benefits are provided is part and parcel of an ERISA plan's basic structure. Petitioner's efforts to characterize ERISA plans as merely financial arrangements that are separate from the provision of benefits must be rejected.

No matter how designated, the HFA Tax Law is a direct "tax" by the State of New York on the assets of an ERISA plan. That ERISA plan is the combination of the NYSA-ILA Medical and Clinical Services Fund (the "Fund") and its medical clinics. By directly taxing the income from health care services provided at the medical clinics in New York (but not in New Jersey), the State of New York is taxing the assets of the ERISA plan simply

because the plan is providing benefits in New York and its assets are there. What happens if the plan's fiduciaries will not pay the tax because they refuse to ignore their duty to preserve plan assets or because the plan has insufficient cash to pay the tax?[11] Can the State of New York seize and close these clinics, thereby stopping the ERISA plan from providing any benefits? If the decision of the Second Circuit is not upheld this could be the consequence of allowing New York, or any other state, to directly tax the assets used by ERISA plans to provide benefits.

ARGUMENT

I. Introduction

This case is really about how this Court and the lower federal courts will interpret this Court's decision in *Travelers*. In *Travelers*, Justice Souter, on behalf of a unanimous Court, apparently articulated a new, additional threshold test to be utilized in determining whether or not ERISA pre-empts a state law in the context of a challenge by commercial insurers and HMO's. While ERISA was obviously implicated, no ERISA plan or employer/plan sponsor was a party in the case. This was because ERISA plans were only indirectly impacted. This is a critical fact in understanding the rationale of *Travelers*. The State of New York and the Solicitor General,

[11] A 57.27% tax, like that imposed by the 1997 NY Hospital Tax Act, could conceivably bankrupt many ERISA plans.

however, would equate a state-imposed increase in hospital bills that are paid by state-regulated and licensed risk bearers in the insurance industry with a direct tax on an ERISA plan, a creature of federal law.[12] Apparently, Petitioner and the Solicitor General believe that since this Court in *Travelers* found that a state law causing an indirect, non-acute economic impact on ERISA plans was not pre-empted, *Travelers* stands for the proposition that Congress intended to allow states to sieze the assets of ERISA plans, by whatever means, including direct taxation.

SIIA believes that Petitioners and Solicitor General grossly misread *Travelers*. The *Travelers'* decision is really a reflection of the difficulty in trying to draw bright lines in an area where individual factual inquiries are necessary. ERISA is an equitable law, emphasizing the need to tailor rights and remedies to individual cases.[13] The general desirability of having fixed principles of law must often give way in equity in order to provide individual justice.[14] This equitable nature of ERISA carries over into

[12] ERISA §502(d). *See also NGS American, Inc. v. Barnes*, 805 F. Supp. 462 (W.D. Tex. 1992), *aff'd*, 998 F.2d 296 (5th Cir. 1993) (plan is a separate legal entity with standing to sue state in declaratory judgment action to prevent imposition of fees and taxes).

[13] *See, generally, Firestone Tire and Rubber Co. v. Bruch* 49 U.S. 101, 109 S. Ct. 948 (1989). Indeed, this case arose as an equitable declaratory judgment action by the Respondent under the authority of ERISA §502(a), 29 U.S.C. §1132(a).

[14] "In equity, as nowhere else, courts eschew rigid absolutes and look to the practical realities and necessities inescapably involved in reconciling competing interests, notwithstanding that those interests have constitutional roots." *Lemon v. Kurtzman*, 411 U.S. 192, 201, 93 S. Ct. 1463 (1973). *See*

ERISA pre-emption litigation, where equitable and constitutional principles meet.[15]

The equitable nature of ERISA is in part explained by the fact that ERISA was passed to encourage the growth and development of a *voluntary*, employer-based, employee benefit system in the United States.[16] Congress realized that a major impediment to the growth of this voluntary system would be state laws.[17] The concept of ERISA pre-emption is not, therefore, the outgrowth of a turf battle between the federal and state governments over who will regulate ERISA plans. Rather, ERISA pre-emption was Congress' choice of what it believed was the

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also Hecht Co. v. Bowles, 321 U.S. 321, 329-330, 64 S. Ct. 587 (1944) ("The essence of equity jurisdiction has been the power of the Chancellor to do equity and to mold each decree to the necessities of the particular case. Flexibility rather than rigidity has distinguished it.")

[15] "[I]n constitutional adjudication as elsewhere, equitable remedies are a special blend of what is necessary, what is fair, and what is workable. 'Traditionally, equity has been characterized by a practical flexibility in shaping its remedies and by a facility for adjusting and reconciling public and private needs.' " *Lemon v. Kurtzman*, 411 U.S. at 200 (*quoting Brown v. Board of Education*, 349 U.S. 294, 300, 75 S. Ct. 757 (1955)).

[16] *Lockheed Corporation v. Spink*, ___ U.S. ___, 116 S. Ct. 1783, 1787 (1996).

[17] "It should be stressed that with the narrow exception specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." Comments of Senator Williams, 120 Cong. Rec. 29933 (1974) (*quoted in Pilot Life Insurance v. Dedeaux*, 481 U.S. 41, 46, 107 S. Ct. 1549 (1987)).

best method to ensure that there will continue to be employee benefit plans to regulate.

> "Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all." *Fort Halifax Packing Co. v. Coyne*, 462 U.S. 1, 13, 107 S. Ct. 2211 (1987).

ERISA touches the lives and business of most Americans in many ways. The factual variations of each of these encounters makes it impossible to establish a single bright line test, or even several bright line tests, that can be articulated to describe the reach of ERISA pre-emption. There are more than one million ERISA regulated pension and welfare plans operating in every state of the Union that provide benefits to well over one hundred million Americans.[18] ERISA plans own over $1 *trillion* worth of stock in American businesses and almost as much in publicly traded bonds.[19] In 1993, ERISA health plans received and paid out more than $235 *billion* for medical bills of plan participants and beneficiaries.[20] These ERISA health plans, and their employer/plan sponsors, are also leading the way in the current dramatic

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[18] For example, in 1990, approximately 77 million Americans participated in 712,000 tax-qualified pension plans. (*See* Exhibit B). In that same year, 148.7 million Americans had employer-provided health care coverage. (*See* Exhibit C). (The exact number of ERISA medical plans is unknown, but it is safe to estimate the number to be in the many hundreds of thousands.)

[19] *See* Exhibit D.

[20] *See* Exhibit E.

restructuring of how health care in America is financed and delivered.

Being such important players in so many areas of American life, ERISA plans necessarily are involved in activities that usually are subject to state regulation, such as the business of risk taking; that is the business of commercial insurers and HMOs. Clearly, Congress did not intend that ERISA plans could totally ignore or be immune from appropriate state regulation, but Congress knew that there was no simple way of defining what state laws should apply to ERISA plans. Instead, Congress chose to set general guidelines for the operation of ERISA plans and their interplay with state law, and then left to the courts the responsibility of applying those principles in individual cases.

As a result of Congress' intentional decision to leave the area of ERISA pre-emption fluid, this Court has been called upon to rule on ERISA pre-emption almost every year since the enactment of ERISA (with three more cases, including this one, being argued this Term) and lower courts have had literally thousands of ERISA pre-emptions cases. Unless and until Congress chooses to either abandon its support of a voluntary employee benefit system in this country or to change the equitable nature of ERISA and ERISA pre-emption, many more cases will follow. That is simply the way ERISA was designed by Congress. Even if *Travelers* is read the way Petitioner or the Solicitor General suggests, ERISA pre-emption cases will abound. Congress, alone, can change that reality.

In SIIA's view, *Travelers* is simply another individualized ERISA pre-emption case. The principles and concepts laid out in *Travelers* will be useful in guiding courts in resolving future ERISA pre-emption cases, but it must be borne in mind that ERISA pre-emption decisions are necessarily highly fact specific. This is, of course, true of *Travelers* itself, which addressed ERISA pre-emption in the context of:

> "[a] New York statute require[ing] hospitals to collect surcharges from patients covered by a commercial insurer . . . whose commercial insurance coverage is purchased by employee health care plans governed by ERISA . . . ."[21]

Travelers did not even involve a surcharge or tax on commercial insurers, much less on ERISA plans. The issue addressed by Justice Souter was whether these new *indirect* costs (that were passed on from patient to commercial insurer to ERISA plan) amounted to the regulation of an ERISA plan's benefit design or choice of administrative scheme.[22]

Rather than trying to shoe-horn this fact pattern into principles established by previous decisions of the Court based on completely different fact patterns,[23] Justice Souter observed that this Court's jurisprudence interpreting

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[21] *Travelers*, 115 S. Ct. at 1673-74.

[22] *Id.* at 1683.

[23] Such as State mandated benefits (*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 705 S. Ct. 2380 (1988)); State wrongful discharge laws (*Ingersoll-Rand v. McClendon*, 458 U.S. 133, 111 S. Ct. 478 (1990)); State sex discrimination laws (*Shaw*), *supra* and State workers compensation laws (*District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580 (1992)).

the phrase "relate to" proved insufficient for this fact pattern and that therefore the Court had to:

> "[L]ook instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 115 S. Ct. at 1677.

SIIA urges this Court and lower courts to read *Travelers* together with all other previous binding ERISA pre-emption decisions, in light of their inherent factual limitations. The desire to create bright lines by citing *Travelers* (or any other decision of this Court), for general, all inclusive principles in order to bring certainty to this area must be resisted. *Travelers*, and the previous ERISA pre-emption decisions, give guidance but do not dictate this Court's results, except in those cases which are factually indistinguishable from the cited authority.

SIIA therefore believes that it is not helpful or appropriate to speculate on what the principles of *Travelers* may mean in a variety of fact patterns not before the Court. Listing a "parade of horribles" regarding state licensure laws or child care centers, as state of New York and the Solicitor General do in their briefs, simply clouds the issues. Once ERISA pre-emption becomes a relevant inquiry with respect to those fact patterns, appropriate decisions will be made. For the moment, it is enough to review the HFA Tax Law as a state law that attempted to tax the assets and operations of an ERISA plan.

II. Direct Taxation or Regulation of an ERISA Plan by a State is Pre-empted By ERISA Unless the State Law is Limited to Plan Activities Unrelated to its Administration or Benefits

A. There is No Single Type of Administrative Scheme for ERISA Plans

While it may be true that most ERISA plans simply pay third-parties to provide employee benefits, it is clear that the definition of employee benefit plan under ERISA is not so limited. As previously noted, Congress chose to lay out ERISA's principles in broad, sometimes vague terms, in order to allow employer flexibility in the provision of employee benefits. This principle is most graphically illustrated by looking at ERISA's definition of "employee benefit plan," the cornerstone of all of ERISA.

In an effort to get its arms around the wide variety of benefit programs in the private sector, Congress chose to look at the benefits provided rather than the method used to provide those benefits. For example, the definition of an "employee welfare benefit plan" found in ERISA §3(1),[24] 29 U.S.C. §1002(1), covers any mechanism utilized

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[24] ERISA Section 3(1) provides that the terms "employee welfare benefit plan" and "welfare plan" means *"any plan, fund, or program* which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was *established or is maintained for the purpose of providing* for its participants or their beneficiaries, *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care *benefits*, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or

by employers (or unions) to provide employees and their families with medical, disability, death and several other types of welfare benefits. There is no administrative scheme or methodology required in order to be an ERISA "employee welfare benefit plan." Quite the contrary, Congress intended to encompass any and all methodologies used to provide employees with the types of benefits within the definition of employee welfare benefit plan so that the protections of ERISA could be enjoyed by as many employees as possible.[25] All agreements and methodologies essential to the provision of welfare benefits are, taken together, the ERISA "welfare benefit plan."[26]

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other training programs, or day care centers, scholarship funds, or pre-paid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 U.S.C. Section 186(c)] (other than pensions or retirement or death, and insurance to provide such pensions) (*emphasis added*)."

[25] The wisdom of this approach was illustrated in *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320 (2nd Cir. 1985), *summarily aff'd*, 477 U.S. 91, 106 S. Ct. 3267 (1986). In *Gilbert*, the employer claimed that its severance pay program was not an ERISA plan because the employer did not want to be covered by ERISA. The employer never (a) published or filed an annual report or a final financial statement, (b) distributed a summary plan description or a statement of material modifications, (c) designated a fiduciary to administer the plan, or (d) informed employees of their rights under ERISA or under the plan. Furthermore, there was no procedure for claims or appeals of a denied claims. Finally, there were no assets segregated to pay severance because all payments were being made from the employer's general assets. The Second Circuit had no problem finding that Congress intended that this kind of arrangement was an ERISA plan.

[26] The definition of "employee pension benefit plan" found in ERISA §3(2), 29 U.S.C. §1002(2) similarly looks at the benefits

In this case, the "employee welfare benefit plan" involved is not just the Respondent Fund. Here, the employee welfare benefit plan is the Fund and the New York and New Jersey medical clinics run by the Fund (which are essential parts of the program by which medical benefits are provided). Both the fund and the clinics are necessary to provide participants and beneficiaries with their medical benefits and therefore both are integral parts of the "employee welfare benefit plan" that is subject to ERISA.

Therefore, the administration of the Fund and the operation of the New York and New Jersey medical clinics together constitute the administration of an ERISA plan.

B. The HFA Tax Law "Relates to" the Administration of this ERISA Plan

As the Second Circuit found, "the Fund provides these health care benefits through three medical centers that it owns and operates, two in New York and one in New Jersey."[27] The administrative scheme for providing benefits under this ERISA plan, therefore, includes the funding and operation of the medical centers. The tax imposed by the HFA Tax Law on the medical centers (and any penalties for failing to pay that tax) are provisions of

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provided (retirement income or deferral of income to termination of covered employment or beyond) rather than the way in which retirement benefits are provided to define "employee pension benefit plan."

[27] *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823, 825 (2nd Cir. 1994). (*"Axelrod I"*).

a state law that directly impacts this scheme of plan administration.

The State of New York is simply wrong, therefore, in its characterization of the benefits provided by the ERISA plan involved in this case. Perhaps based upon its traditional role of regulating the business of insurance, New York in its brief erroneously states:

> "[T]he state may regulate ERISA plan-owned hospitals because the ownership of the hospital is not part of the plan's benefit structure. The benefit structure by the NYSA plan in this case is health care coverage. The plan assumes the obligation for the payment of health care services that are provided to plan participants. This benefit, health care coverage, is the same regardless of whether a plan purchases it by self-insuring, purchasing HMO memberships, purchasing traditional indemnity insurance, or providing services in kind." Petitioner's Brief at 21-22.

To the contrary the *employee benefits are the health care services provided at the medical clinics in New York and New Jersey*, not "coverage" or payments to third parties for health care services rendered. The ownership of the medical centers is not "incidental to the plan's benefit structure,"[28] the *ownership of those centers is the way that health benefits are provided.*

To characterize this ERISA plan as being no different, for ERISA pre-emption purposes, than ERISA plans that pay third parties for medical services is exactly the type

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[28] Petitioner's Brief at 22.

of gamesmanship that Congress feared when it included the so-called "deemer clause" in ERISA.[29] Even if one ignores the fact that the New York and New Jersey medical centers only exist because of the direct benefits provided by this ERISA plan and limits the inquiry to the payments received by the medical centers from other ERISA plans and their participants, the same impermissible impact on this ERISA plan's benefits and administrative scheme occurs.[30]

In the words of the Second Circuit in *Axelrod I*,

> "Restructure[ing] its finances so that the funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers . . . would alter the Fund's established method of administration and would require it to implement procedures for its New York facilities to differ from

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[29] ERISA §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B). The "deemer clause" protects ERISA plans from states trying to extend the "savings clause" of §514(b)(2)(A) to ERISA plans by deeming them "to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." The same principle equally applies to New York's attempt to "deem" this ERISA plan's benefits to be "health care coverage" (an insurance law concept), rather than the direct provision of benefits, in order to avoid ERISA pre-emption.

[30] It is not clear whether the State of New York is willing to so limit the inquiry. The Solicitor General seems to assume that is the case. *See Amicus* Brief United States at 4 n. 3.

those of its New Jersey facility." *Axelrod I*, 27 F.3d at 827-28.

It is hard to imagine a more blatant example of an "administrative and financial burden" that frustrates the achievement of the "nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1697.

III. Petitioner and *Amicus* United States Misread *Travelers*

As noted above, both the State of New York and the Solicitor General have asserted in their briefs that *Travelers* should be read to support the proposition that Congress intended state laws regulating traditional areas of local concern and state laws of general applicability to be exempt from ERISA pre-emption.

The Solicitor General argues that the case law interpreting ERISA has created three categories of state law which are pre-empted: (i) areas where ERISA provides law or remedies, (ii) state laws imposing rules on ERISA plans regarding their structure and administration, and (iii) state laws dictating what benefits should be provided. *Amicus* Brief United States at 9-10.

> "There is no basis for extending pre-emption under §514(a) to state laws of general applicability that do not fall into any of the above categories." *Id.* at 10.

Any state law of general applicability outside of these three categories presumptively does not "relate to" an ERISA plan and is not, therefore, pre-empted.

Fortunately, the scheme established by Congress does not share the same presumptions. First, all state laws which "relate to" ERISA plans are pre-empted, whether laws of general applicability or not. Then Congress set forth certain exemptions to ERISA pre-emption for traditional areas of state regulation, *e.g.*, insurance, banking and security laws, state criminal laws, and state domestic relations laws. Congress specifically noted that tax laws relating to ERISA plans were pre-empted.[31] Congress set forth no rules on when state laws "relate to" ERISA plans, but left that to the courts to determine case by case.

Petitioner, *citing Travelers*, would do even more violence to the longstanding principles of ERISA pre-emption.

> "In *Travelers*, 115 S. Ct. at 1679, this Court held that state laws of general applicability in areas of traditional state regulation do not relate to plans, even if they have an economic impact upon plan choices, so long as they do not dictate or restrict plan benefit structure or plan administration."[32]

And again later on in Petitioner's brief:

> "In both *Travelers* and in this case, the state law has an effect on ERISA plans only because, and to the extent that, plans have chosen to engage

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[31] ERISA §514(b)(5)(B)(i), 29 U.S.C. §1144(b)(5)(B)(i).

[32] Petitioner's Brief at 8.

> in activity that is covered by the generally applicable state law. That incidental effect is too 'tenuous, remote, or peripheral' to warrant a finding that the law 'relates to' ERISA plans."[33]

Both Petitioner and the Solicitor General sought to base their revisionist readings of ERISA pre-emption jurisprudence on this Court's references to "fields of traditional state regulation"[34] and "laws of general applicability."[35] None of these general references in *Travelers* justify the reading of Petitioner or *Amicus* United States, a reading which amounts to a total reversal of 22 years of ERISA pre-emption jurisprudence.

Travelers' reference to "fields of traditional state regulation" was for the purpose of noting the judicial assumption against invalidating a state's exercise of its historic police powers unless Congress clearly manifested that intent. In ERISA §§514(a) and (b) Congress did manifest that intent.

Congressional concern with respecting areas of law traditionally regulated by the states is the reason for most of ERISA §514(b)(2), 29 U.S.C. §1144(b)(2). Such areas of traditional state regulation as (a) state regulation of the businesses of insurance, banking and securities are all carved out from ERISA's broad pre-emption scheme (b) generally applicable state criminal law, and (c) domestic relations law. To now suggest that Congress forgot to

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[33] Petitioner's Brief at 26.

[34] *Travelers*, 115 S. Ct. at 1676.

[35] *Id.* at 1680 (*quoting Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n. 1).

exclude from ERISA pre-emption other areas of traditional state regulation is absurd.[36] Congress clearly has understood that such laws must be specifically listed in ERISA §514(b) to be saved from pre-emption under ERISA §514(a).

The best example of Congress' understanding of how ERISA §§514(a) and (b) fit together is in the area of domestic relations law, as much, if not more, "an area of traditional state regulation" as is health care delivery. Nonetheless, Congress found it necessary to amend

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[36] The *Amicus* Brief of the United States, at n. 16, makes a half-hearted effort to fill this hole in its argument. (Petitioner does not try.) The Solicitor General contends that some traditional areas of state regulation and taxation (*e.g.*, social welfare activities) do not "relate to" ERISA plans because ERISA does not "provide law" on those subjects. Therefore, says the Solicitor General, these laws need no saving from pre-emption by ERISA §514(b). The Solicitor General does not explain why other areas of traditional state regulation and taxation, such as insurance, banking and securities laws (for which ERISA also provides no law) need to be saved from pre-emption by ERISA §514(b) if these areas of law do not "relate to" ERISA plans. The short answer is, of course, that test of ERISA pre-emption is not and never has been whether ERISA "provides law" in a particular area of concern or regulation. Moreover, the Solicitor General ignores a basic principle of statutory construction, *i.e.*, where "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17, 100 S. Ct. 1905 (1980). The legislative intent under ERISA is for expansive, not restrictive, pre-emption of state laws. *See Pilot Life*, 481 U.S. at 46 ("[T]he express pre-emption provisions are deliberately expansive and designed to establish [benefit] plan regulation as exclusively a federal concern").

ERISA §514(b) twice[37] to specifically exempt from ERISA pre-emption under §514(a) state laws dealing with Qualified Domestic Relations Orders and Qualified Medical Child Support Orders. Even these statutory exemptions from ERISA pre-emption do not protect all state domestic relation orders. Domestic relations court orders which fail to be "qualified," (as that term is defined by Congress and not by state legislatures or courts) are not protected by ERISA §514(b)(7) from ERISA pre-emption.

The reference in *Travelers* to "laws of general applicability" upon which Petitioner relies involved a quote from *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 n. 1, where this Court sought to explain the "too tenuous, remote, peripheral connection" test first enunciated in *Shaw*, 463 U.S. at 100 n. 21. The reference never sought to exempt such state laws from ERISA pre-emption generally, as Petitioner now contends. The Court's discussion in *Greater Washington Bd. of Trade*, merely underscores the difficulty of limning the scope of ERISA pre-emption with respect to such state laws.

The holding in *Travelers* is most succinctly described in that decision's penultimate paragraph. A state law that indirectly increases the health insurance premiums ERISA plans must pay is not pre-empted because it does not directly or indirectly force ERISA plans to change benefits or restrict their choice of insurers. No amount of selective citation can transform this straight forward

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[37] First, in the Retirement Equity Act of 1984, P.L. 98-397, to allow for QDROs, and next in the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, sanctioning QMSCOs.

holding into support for the radical proposition described in the briefs by Petitioner and the Solicitor General.

CONCLUSION

The broad pre-emption provision in ERISA was expressly designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of the pre-emption provision in connection with state tax laws, such as the one at issue here, that directly impede the ability of ERISA plans to provide benefits would violate Congress' clear mandate to free voluntary ERISA plans from the reach of intrusive and conflicting state law. The failure to uphold the Second Circuit's decision would open the door for state legislatures throughout the United States, in flawed reliance on a mythical "traditional local law" or "law of general application" standards, to enact statutes which directly tax ERISA plans. Such a development would threaten the very viability of

ERISA plans and self-insurance as an attractive alternative for providing health benefits to millions of employees and their families.

Respectfully submitted,

Dated: Detroit, Michigan
December 30, 1996

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EXHIBIT A

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SECTION: HEALTH CARE CAN; Pg. 7

LENGTH: 2669 words

HEADLINE: N.Y. Health Care Reform Act of 1996; Rate Regulation Abandoned

BYLINE: MARK THOMAS; Mark Thomas is general counsel of the Healthcare Association of New York State (HANYS) in Albany.

BODY:

THE PASSAGE of the New York Health Care reform Act of 1995, as embodied in Assembly Bill 11330, marks a major shift in New York State health care policy.

Since 1983, New York State hospitals have been operating under a rate-regulated systems – the New York Prospective Hospital Reimbursement Methodology (NYPHRM), a reimbursement system under which the state determined all non-Medicare payments for hospital inpatient care. The NYPHRM system extended state control over hospital financing, continued stringent regulatory control, and established a mechanism – the bad debt/charity care pools – to partially compensate hospitals for caring for individuals with no insurance or ability to pay.

Throughout its history, the focus of the NYPHRM legislation has been broadened beyond hospital inpatient financing and has addressed a variety of other issues

from insurance for children to excess medical malpractice insurance for physicians. The NYPHRM approach, however, has become increasingly out of step with the lightning-speed transformation of the health care delivery system.

In recognition of the changing health care environment, the preamble to the Reform Act states in part: "New York York [sic] should move toward a system of negotiated rates for all non-Medicare payers; the State should maintain a significant role in assuring quality and access to care; and the State should continue to provide for the financing of public policy objectives unlikely to be addressed through market forces."

In order to achieve these purposes and to allow for a transition period, the Act extends NYPHRM until Dec. 31, 1996, and replaces it with a market-driven, hospital financing system accompanied by a cornucopia of health-related initiatives. In addition, it provides a unique opportunity for providers seeking to assume risk and contract directly – without an insurance intermediary – with patient groups by authorizing the operation of integrated delivery systems.

Beginning Jan. 1, 1997, payments for hospital impatient [sic] care will change dramatically with hospitals, Blue Cross plans, commercial insurance carriers, health maintenance organization (HMOs), and self-insured plans authorized to negotiate inpatient prices. Medicaid free [sic]-for-service payments will continue to be set by the state through 1999 and will not be negotiated or selectively contracted. Workers' compensation/no-fault

rates will be set at the Medicaid fee-for-service rates, and these carriers will not be allowed to negotiate payments.

Under the state-controlled NYPHRM system, many so-called public goods, such as the provision of charity care, the extensive graduate medical education infrastructure and various health insurance programs, were financed by mandatory rates and rate surcharges paid by insurers and other payers.

Reflecting the fear that financing for these societal goods would be abandoned under a purely negotiated price system, the Reform Act establishes three pools – indigent care, health care initiatives and graduate medical education (GME) – to fund these and other public goods, with total annual funding of these pools expected to reach approximately $ 2.6 billion. While these pools are a new creation, they are funded by the same sources as under NYPHRM – the entities, public and private, that pay for hospital and health care.

Recognizing that hospitals will continue to care for individuals who have no insurance or who cannot pay for their health care services, the Reform Act creates a new mechanism – the indigent care pool – for financing and distributing uncompensated care funds for the years 1997 through 1999. The indigent care pool will provide approximately $ 738 million to hospitals and $ 48 million to diagnostic and treatment centers for uncompensated care.

Each third-party payer except Medicare, Medicaid and workers' compensation/no-fault carriers will be allowed to make payments to the indigent care pool using a formula based on the payer's prior expenditures for

hospital inpatient and outpatient care, services provided by diagnostic and treatment centers that provide a comprehensive range of primary health care services or ambulatory surgical services, and freestanding clinical laboratories. Those third-party payers electing to make payments directly to the pool on a periodic basis would pay 8.18 percent of its prior annual cost of these services.

A payer may alternatively elect to pay an indigent care surcharge on an "encounter" basis when patient services are received. The encounter surcharge would equal the assessment described above plus an additional 24 percent. Under this scheme, the provider remits the entire surcharge to the pool, but is able to retain 2 percent to cover the administrative costs of collecting the encounter payments. The encounter assessment would apply to the same range of services and providers, i.e., hospitals, certain diagnostic and treatment centers and free-standing laboratories.

It is anticipated that the large majority of third-party payers, including self-insured plans, will opt to make periodic payments directly to the pool to avoid the 24 percent additional charge imposed under the "encounter" approach.

Since Medicare is a federal program, it will not pay any surcharge while Medicaid and workers' compensation/no fault payers will pay a flat assessment that is added to each hospital bill; the election option is not available.

Funds generated by these assessments would be primarily distributed to hospitals across the state based on a statutory "need" formula. Those with greater amounts of

charity care and bad debts, and publicly operated hospitals, would have a greater percentage of their need met under the formula. Also eligible for indigent care payments are comprehensive diagnostic and treatment centers that are voluntary, non-profit or publicly sponsored, provide a comprehensive range of primary health care services, and can demonstrate losses from a disproportionate share of uncompensated care.

Graduate medical education (GME) costs, i.e., those associated with training interns and residents, will be funded for non-Medicare payers at $ 1.385 billion per year over the three year period, 1997-1999, or approximately 75 percent of the current non-Medicare funding level of $ 1.85 billion.

Medicaid and workers' compensation/no-fault insurers will continue to pay full GME costs as part of the state-set fee-for-service payments. In the case of Medicaid beneficiaries enrolled in managed care plans, separate payment of GME, on a per discharge basis, will be made. Total Medicaid GME payment is projected to be $ 791 million in 1997, and workers' compensation/no-fault GME payments are projected to be $ 50 million.

Third-party payers – Blue Cross, commercial insurers HMOs for their non-Medicaid/non-Medicare business, and self-insured funds – will contribute to a GME pool, to be known as the "professional education pool," which is to be funded at $ 545 million per year for the three-year period. Funds from this pool are allocated on a regional basis, in order that amounts collected from payers in a region will be distributed to teaching programs in that same region.

As is the case with the indigent care pool, third-party payers will have a choice of payment options. The basis for the GME funding surcharge, however, is fundamentally different. A payer may elect to make periodic payments directly into the GME pool using a formula not based on prior health expenditures but rather on the payer's number of "covered lives." The determination of covered lives, their value and the payment amount is highly complex and is set forth in detailed statutory language.

Similar to the uncompensated care funding approach, a payer may alternatively choose to pay a GME surcharge on an encounter basis, i.e., as a surcharge on the hospital bill. Here again, the encounter surcharge will equal an amount equivalent to the "covered lives" levy plus an additional 24 percent. Each teaching hospital will receive a monthly payment from the applicable regional pool based on its adjusted share of a region's total adjusted GME spending.

Health Care Initiatives

A third pool of funds, the health care initiatives pool, is established to support programs designed to expand access to health insurance, monitor and improve quality, provide for restructuring of the health care system and retraining for the health care workforce. Funding for this pool is derived from the same mechanism as is used for the uncompensated care pool.

Among the dozen-plus programs to be funded from the initiatives pool are:

* The Child Health Insurance Program (CHIP), also known as Child Health Plus, which provides health insurance to low-income children. CHIP was created in 1991 with coverage limited to primary and preventive care of children under the age of 13. In 1994, the program became available to children under the age of 15. Effective Jan. 1, 1997, it becomes available to children under the age of 19. Also effective Jan. 1, 1997, CHIP coverage is extended to all inpatient health care services except mental health, substance abuse and alcohol treatment services. The total amount of funding for CHIP is $ 120.6 million in 1997, rising to $ 181 million in 1999. As before, CHIP is available only to children who do not have equivalent coverage under another plan.

* Funding of $ 6 million is provided to establish the New York State Small Business Health Insurance Partnership Program, which is designed to assist eligible employers to purchase small group health insurance policies for their full-time employees and dependents. To participate in the program, eligible employers must submit applications to the Commissioner of Health for approval.

* Funding of $ 5 million is available for the voucher insurance program, a demonstration program to assist individuals and families residing in specified urban and rural areas to buy health care coverage through insurers, HMOs and integrated delivery systems.

* An annual minimum of $ 20 million will be available for the restructuring of health care facilities. The restructuring funds are allocated to assist facilities in the formation or strengthening of networks, affiliations or

other business combinations designed to provide long-term financial stability; to offset the costs of engaging management, legal or accounting consultants; and for loans for the payment of debt service or bonds, notes or other obligations issued or incurred by the State Dormitory Authority or the New York State Medical Care Facilities Finance Agency.

* Grant funding – $ 50 million in 1997 – for training and retraining of displaced health care workers will be made available on a regional basis in areas where significant job losses have occurred or are anticipated as a result of changes in the health care field. Among the organizations eligible to seek these funds are hospitals, long-term care facilities, labor unions, labor-management organizations, managed care organization and trade associations.

* Grant funding of $ 30 million is available to assist health care providers in the transition to competitive system. Funds may be used for developing health care provider networks, promoting the reconfiguration and restructuring of health care delivery, and developing information systems to facilitate integration.

* An annual total of $ 8 million will be provided to fund quality improvement and quality measurement grants, to be awarded based on the recommendations of a newly created Task Force on Health Care Quality Improvement and Information Systems.

* Grant programs also are established for many other public and primary health care programs, including emergency medical services programs, development of special HIV services for infants and pregnant women, and expansion of primary care through the physician

loan repayment program, the primary care practitioner scholarship program, and minority participation in medical education.

Using funds from the initiatives pool, the Reform Act also provides $ 17 million in total assistance for rural health care providers. These funds, to be available as direct funding and grants, are designed to support facility improvements, the purchase of major medical and non-medical equipment, the development of management information systems, the transition of rural hospitals into managed care, and the expansion of primary and preventive care services in rural areas.

Creation of IDS

By the addition of new §4408-a to the Public Health Law, the Health Care Reform Act creates a new category of managed care licensure known as "integrated delivery systems" (IDS), often commonly referred to as provider-sponsored networks. An IDS would be a legal entity composed of or controlled by one or more affiliated providers which would be authorized to deliver comprehensive health care services on a capitated [sic] basis to certain defined patient groups.

Providers eligible to affiliate the operate as an IDS include hospitals, nursing homes, home health care agencies, substance abuse providers, residential treatment facilities for the mentally retarded and mentally ill, and physicians. One significant limitation is a provision that prohibits publicly traded corporations from operating an IDS, mirroring New York's similar unique prohibition on

publicly traded companies' ownership of hospitals, nursing homes and clinics.

Integrated delivery systems will be regulated primarily by the Department of Health, with significant input from the Insurance Department on issues relating to fiscal solvency and the development of premium rates. A qualified IDS must deliver comprehensive HMO-like services with at least 75 percent of these services delivered through its network of affiliated providers, all of which must share "substantial financial risk" in the venture's operation.

In recognition of this structure, the Superintendent of Insurance is authorized to develop unique solvency standards for integrated delivery systems which would not exceed HMO standards and which "recognize and consider the specific delivery components, operational capacity and financial capability" of an IDS. This provision allows the Superintendent to promulgate solvency standards which more appropriately recognize the risks inherent in the delivery of services as contrasted with the higher risks involved when a insurance entity must purchase services.

An approved IDS would be eligible to deliver services to the following groups on a capitated basis:

* Medicare patients, if and when the federal government authorizes IDS risk assumption for this population;

* Medicaid patients and commercial enrollees; or

* Medicare (subject to federal approval noted above), Medicaid patients and commercial enrollees, including self-insured plans.

The IDS authorization expires on April 1, 2002, and no new approvals to operate will be issued after that date and no new enrollee approvals would be authorized.

Conclusion

The Health Care Reform act is not a simple deregulation of the old hospital pricing system. Designed to serve a multitude of purposes, the Act includes many new approaches to impose financing mandates on payers while simultaneously moving the multi-billion dollar hospital system into the open marketplace.

It remains to be seen whether the funding schemes will prove adequate and withstand potential challenges. The surcharge options offered to payers, including self-insured plans and third-party administrators, as well as insurers, are accompanied with various reporting and other administrative requirements, raising the potential for yet another round of ERISA preemption litigation.

Undoubtedly, the ACT's complexity will require a series of ameliorative statutory amendments. At present, though, it stands as a monumental effort to promote the evolution of the state's hospital system into the next century.

LANGUAGE: ENGLISH

LOAD-DATE: September 03, 1996

EXHIBIT B

Table 5.1
Private Pension Plans and Participants

Summary of Private-Sector Qualified Defined Benefit and Defined Contribution Plans and Participants, 1975–1990

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
	(thousands)															
Total Plans	311	360	403	443	471	489	546	594	603	601	632	718	733	730	731	712
Defined benefit[a]	103	114	122	128	139	148	167	175	175	165	170	173	163	146	132	113
Defined contribution[a]	208	246	281	315	331	341	378	419	428	436	462	545	570	584	599	599
Defined contribution as percentage of total	67%	68%	70%	71%	70%	70%	69%	71%	71%	73%	73%	76%	78%	80%	82%	84%
	(millions)															
Total Participants	45	48	50	52	55	58	61	63	69	74	75	77	78	78	76	77
Defined benefit[b]	33	34	35	36	37	38	39	39	40	41	40	40	40	41	40	39
Defined contribution[b]	12	13	15	16	18	20	22	25	29	33	35	37	38	37	36	38
Defined contribution as percentage of total	27%	28%	30%	31%	33%	34%	36%	39%	42%	45%	47%	48%	49%	48%	48%	50%
Active Participants	31	32	33	34	35	36	37	37	39	40	40	41	42	42	43	42
Primary plan is defined benefit	27	27	28	29	29	30	30	29	30	30	29	29	28	28	27	26
Primary plan is defined contribution	4	5	5	5	6	6	7	8	9	10	12	13	13	14	15	16

Source: Employee Benefit Research Institute tabulations based on John A. Turner and Daniel J. Beller, eds., *Trends in Pensions*, Second edition (Washington, DC: U.S. Department of Labor, 1992); U.S. Department of Labor, Pension and Welfare Benefits Administration, *Private Pension Plan Bulletin* (Winter 1993); and U.S. Department of Labor, Pension and Welfare Benefits Administration, *Private Pension Plan Bulletin* (Summer 1993).

[a]Excludes single participant plans.

[b]Active, separated vested, survivors, and retired. Not adjusted for double counting of individuals participating in more than one plan.

EXHIBIT C

Table 8.1
Health Insurance Coverage of the Elderly and Nonelderly

Nonelderly and Elderly Populations with Selected Sources of Health Insurance Coverage, 1989–1993

Source of Coverage	Total Population					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	243.3	246.0	248.7	251.7	254.2	256.9
Total with Private Health Insurance	180.4	178.9	178.4	177.5	178.1	178.0
Employer coverage	150.2	148.7	150.0	148.0	148.6	147.4
Other private coverage	30.3	30.3	28.6	29.6	29.7	31.2
Total with Public Health Insurance	54.5	58.1	61.2	63.2	63.6	65.8
Medicare	31.5	32.3	32.9	33.7	33.2	33.0
Medicaid	21.1	24.2	26.8	28.5	29.4	31.6
CHAMPUS/CHAMPVA[b]	7.0	7.0	7.1	6.9	6.9	6.8
No Health Insurance	34.7	36.0	36.6	38.9	40.1	41.2
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	74.2	72.7	71.7	70.5	70.1	69.3
Employer coverage	61.8	60.4	60.3	58.8	58.5	57.4
Other private coverage	12.4	12.3	11.5	11.8	11.7	12.1
Total with Public Health Insurance	22.4	23.6	24.6	25.1	25.0	25.6
Medicare	12.9	13.1	13.2	13.4	13.1	12.9
Medicaid	8.7	9.8	10.8	11.3	11.6	12.3
CHAMPUS/CHAMPVA[b]	2.9	2.8	2.9	2.7	2.7	2.6
No Health Insurance	14.3	14.6	14.7	15.4	15.8	16.1

(continued)

Table 8.1 (continued)
Health Insurance Coverage of the Elderly and Nonelderly

Source of Coverage	Nonelderly					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	213.7	215.9	218.1	220.8	223.8	226.2
Total with Private Health Insurance	160.4	158.3	157.7	156.6	157.5	157.7
Employer coverage	140.8	138.7	139.8	138.0	138.7	137.4
Other private coverage	19.7	19.7	18.0	18.8	19.0	20.8
Total with Public Health Insurance	26.2	29.2	31.7	33.4	34.3	36.3
Medicare	3.2	3.5	3.5	4.0	3.9	3.7
Medicaid	18.5	21.6	23.9	25.6	26.5	28.9
CHAMPUS/CHAMPVA[b]	5.9	5.9	5.9	5.7	5.8	5.6
No Health Insurance	34.4	35.7	36.3	38.5	39.8	40.9
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	75.0	73.3	72.3	70.9	70.4	69.7
Employer coverage	65.9	64.2	64.1	62.5	62.0	60.8
Other private coverage	9.2	9.1	8.2	8.5	8.5	9.2
Total with Public Health Insurance	12.2	13.5	14.5	15.1	15.3	16.1
Medicare	1.5	1.6	1.6	1.8	1.8	1.6
Medicaid	8.7	10.0	11.0	11.6	11.8	12.8
CHAMPUS/CHAMPVA[b]	2.8	2.7	2.7	2.6	2.6	2.5
No Health Insurance	16.1	16.6	16.6	17.4	17.8	18.1

(continued)

Table 8.1 (continued)
Health Insurance Coverage of the Elderly and Nonelderly

Source of Coverage	Elderly					
	1989	1990	1991	1992	1992 (revised)	1993
	(weight based on 1990 census)[a]				(weight based on 1980 census)[a]	
	(millions)					
Total Population	29.6	30.1	30.6	30.9	30.4	30.7
Total with Private Health Insurance	20.0	20.6	20.7	20.9	20.6	20.3
Employer coverage	9.4	10.0	10.1	10.1	9.9	9.9
Other private coverage	10.6	10.6	10.6	10.8	10.7	10.4
Total with Public Health Insurance	28.3	28.9	29.5	29.8	29.4	29.4
Medicare	28.2	28.8	29.4	29.7	29.3	29.3
Medicaid	2.6	2.6	2.9	2.9	2.9	2.7
CHAMPUS/CHAMPVA[b]	1.1	1.1	1.2	1.2	1.2	1.2
No Health Insurance	0.3	0.3	0.3	0.4	0.3	0.4
	(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100%	100.0%
Total with Private Health Insurance	67.7	68.4	67.7	67.7	67.8	66.0
Employer coverage	32.0	33.2	33.1	32.6	32.7	32.3
Other private coverage	35.7	35.2	34.7	35.0	35.2	33.7
Total with Public Health Insurance	95.8	96.0	96.3	96.6	96.6	95.8
Medicare	95.6	95.7	96.0	96.2	96.3	95.5
Medicaid	8.7	8.6	9.5	9.4	9.4	8.8
CHAMPUS/CHAMPVA[b]	3.7	3.7	3.8	3.9	3.8	3.8
No Health Insurance	1.0	1.0	0.9	1.2	1.1	1.2

Source: Sarah C. Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1994 Current Population Survey," *EBRI Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

Note: Details may not add to totals because individuals may receive coverage from more than one source. See Appendix B for a technical explanation of this source.

[a]The 1989 data through the first set of 1992 data are based on 1980 census-based population controls. The second set of 1992 data (as revised) and 1993 data are based on 1990 census-based population controls. While the change in weighting has little effect on the percentage distributions, it does effect levels. Thus, by reweighting the 1992 data, these numbers may more accurately be compared with the more recent 1993 data.

[b]Includes only the retired military and members of their families provided coverage through the Civilian Health and Medical Program for the Uniformed Services and the Civilian Health and Medical Program of the Veterans Administration. Excludes active duty military personnel and members of their families.

EXHIBIT D

Table 6.9
Pension Assets

Financial Assets[a] of Private and Public Pension Plans, Selected Years 1950–1993

	1950	1960	1970	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993
							($ billions)						
All Funds and Reserves	$25	$91	$241	$902	$1,982	$2,323	$2,515	$2,743	$3,230	$3,252	$3,845	$4,135	b
Private Funds	13	57	153	628	1,435	1,692	1,818	1,938	2,279	2,265	2,734	2,876	b
Private Trusteed Funds	7	38	112	470	1,088	1,282	1,359	1,422	1,706	1,629	2,056	2,181	$2,336
Equity	1	17	67	224	464	551	539	610	735	658	889	946	1,097
Bonds	5	18	33	128	346	403	433	455	539	559	640	677	700
Cash items	c	1	2	49	123	153	178	207	238	224	273	281	255
Other assets	1	3	11	69	154	176	209	150	194	189	254	277	302
Private Insured Reserves	6	19	41	158	347	410	459	516	573	636	678	695	b
Separate accounts	d	d	5	31	74	88	88	98	115	122	159	186	b
General accounts	6	19	36	127	273	322	371	418	458	514	519	509	b
Public Funds	12	34	88	274	547	631	697	805	951	987	1,111	1,259	1,396
State and local government	5	20	60	197	398	462	508	597	722	737	834	955	1,065
Federal Civilian	4	10	23	74	145	163	182	200	220	241	266	292	319
Railroad	3	4	5	3	4	6	7	8	9	9	11	12	12

Source: Employee Benefit Research Institute (EBRI) tabulations of U.S. Federal Reserve Board, *Flow of Funds Accounts Flows and Outstandings, Fourth Quarter 1993* (Washington, DC: Board of Governors of the Federal Reserve System, 1993); and EBRI tabulations of American Council of Life Insurance, *1993 Life Insurance Fact Book Update* (Washington, DC: American Council of Life Insurance, 1993).

[a]Includes only those assets included within Federal Reserve Board's Flow of Funds accounts. The Flow of Funds accounts are restricted to only certain "financial assets" and therefore exclude such assets as real estate, physical property, and receivables. All nonequity holdings are estimated at book value. Short-term government bonds and all bonds with long-term original date-to-maturity are classified as bonds. Mutual funds are classified as other assets.

[b]Data are not available.

[c]Less than $500 million.

[d]No assets in this category.

EXHIBIT E

Table 2.2
Employer Spending for Benefits

Employer Outlays for Selected Employee Benefits by Function, Selected Years 1960–1993

	1960	1970	1980	1990	1991	1992	1993
				($ billions)			
Total Compensation	$296.7	$618.3	$1,644.4	$3,292.3	$3,399.4	$3,585.4	$3,774.4
Wages and Salaries[a]	272.8	551.5	1,376.6	2,745.0	2,816.0	2,954.8	3,100.8
All Benefits	23.7	66.2	265.8	547.3	583.4	630.6	673.6
Retirement Income Benefits	14.2	40.3	151.6	260.6	275.1	294.6	311.1
Social Security Old-Age, Survivors, and Disability Insurance	5.6	16.2	55.6	137.0	142.5	149.4	156.3
Private employer pension and profit sharing	4.9	13.1	55.3	49.5	54.3	62.7	68.2
Public employer retirement plans	3.7	11.0	40.7	74.1	78.3	82.5	86.6
federal civilian employee retirement[b]	0.8	2.2	7.4	16.1	17.9	19.4	20.8
state and local government retirement	1.8	5.1	19.1	33.3	34.0	35.3	36.8
military retirement[c]	0.8	3.2	12.5	22.1	23.8	25.1	26.3
railroad retirement	0.3	0.5	1.7	2.6	2.6	2.7	2.7
Health Benefits	3.4	14.6	73.0	211.7	230.6	254.7	275.6
Medicare Hospital Insurance	0.0	2.3	11.6	33.6	34.7	36.5	38.2
Group health insurance	3.4	12.1	61.0	176.6	194.2	216.5	235.6
Military medical insurance[d]	0.0	0.2	0.4	1.5	1.7	1.7	1.8
Other Employee Benefits	6.1	11.3	41.2	75.0	77.7	81.3	86.9
Unemployment insurance[e]	3.0	3.8	16.4	22.9	22.2	25.6	28.4
Workers' compensation	2.0	4.6	19.3	46.0	49.3	49.8	52.6
Group life insurance	1.1	2.9	5.5	6.1	6.2	5.9	5.9

Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, July 1994* (Washington, DC: U.S. Government Printing Office, 1994); and *The National Income and Products Accounts of the United States: Statistical Supplement, 1959–1988*, Vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).

[a]Includes paid holidays, vacations, and sick leave taken.

[b]Consists of civil service, foreign service, Public Health Service officers, Tennessee Valley Authority, and several small retirement programs.

[c]Includes the U.S. Coast Guard.

[d]Consists of payments for medical services for dependents of active duty military personnel at nonmilitary facilities.

[e]Consists of state, railroad employee, and federal employee unemployment benefits; special unemployment benefits; and supplemental unemployment benefits.